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APR 2 2 2011

Board of Registration in Medicine

Application #: 248446 1405

Board of Registration in Medicine - 200 Harvard Mill Square, Suite 330
Wakefield, MA 01880 Telephone: (781) 876-8210 Fax: (781) 876-8383
Website: www.massmedboard.org

INITIAL LIMITED LICENSE APPLICATION

IMPORTANT: Read the accompanying instructions before completing this form, and print legibly or type your answers. Please attach a $100.00 check payable to the Commonwealth of Massachusetts.

CHECK ONE: ☒ Graduate of a Medical School in the United States, Canada, or Puerto Rico (USMG)
☐ Graduate of an International Medical School (IMG)

NOTE: GRADUATES OF INTERNATIONAL MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS

SECTION A: Sworn Statement To Be Completed by Applicant

1-A. Name: (Last) Montoya (First) Ryan (MI) J

1-B. Other Name(s): _____

	YES	NO
1) Have you ever been known under a different name or combination of names?	☐	☒
2) Have you ever been licensed under a different name?	☐	☒
3) Have you ever applied for licensure, or applied to sit for an examination, or taken an examination under a different name?	☐	☒

If you answer **yes**, you must provide additional information. (See instructions.)

2. Current Address: _____ Telephone Number _____

City: _____ State: _____ Zip: _____

3. Date of Birth: ____ ____ ____ (Month Day Year) Place of Birth: _____

E-mail Address: _____

4. Sex: ☒ Male ☐ Female 5. Social Security Number: _____

6. Name of Massachusetts Training Program: University of Massachusetts, Family Medicine

55 Lake Avenue North (Street Address) Worcester (City)

Date Received: 4 / 22 / 11

Check #: 0250488645

Check Amount: $ 100 -

Initials: KB

PRINT NAME Ryan J. Montoya

7. Name of premedical school(s): Harvard College
   Location: Cambridge, MA, USA
   (City, State, Country)

8. Name of medical school(s): University of Massachusetts Medical School
   Location: Worcester, MA, USA
   (City, State, Country)

   Date of Graduation: 06 /05 /2011 Degree: ☑ M. D. ☐ D. O. Other (specify)_____
   (Month) (Day) (Year)

   (See Limited Instructions, (page 3), for completing Medical Education forms for fourth year medical school students.)

9. Have you had previous postgraduate training in the United States? ◉ No ○ Yes
   Name of Postgraduate Training Program _____
   City: _____ State: _____
   Training Dates: From: ___/___/___ To: ___/___/___ Specialty: _____

   Name of Postgraduate Training Program _____
   City: _____ State: _____
   Training Dates: From: ___/___/___ To: ___/___/___ Specialty: _____
   (If additional space is needed, please continue your answer on a separate sheet of paper.)

10. List states (abbreviations) where you *ever* had a license to practice medicine (include residency training licenses).
    _____ ☐(Full) _____ ☐ (Full) _____ ☐ (Full) _____ ☐(Limited) _____ ☐ (Limited)

11. Please indicate **all** the licensing examinations that you have have completed with a passing score:

    USMLE ☑ Step 1 ☑ Step 2 (CK) ☑ Step 2 (CS) ☐ Step 3

    NBME ☐ Part 1 ☐ Part II ☐ Part III ☐ COMLEX ☐ Level 1 ☐ Level 2 ☐ LMCC

YES NO

12-A. If you are a USMG, have you taken more than 4 years to complete medical school?

12-B. If you are an IMG, have you taken more than 6 years to complete medical school? If yes, you must provide additional information. (See instructions).

13. Has *more than one year* passed between the date of your graduation from medical school and the anticipated start date of your limited licensure in Massachusetts?

    If yes, you must provide additional information with your curriculum vitae and include the months and dates of any gaps in your professional activities since graduation from medical school. (See instructions.)

SECTION C: Read the instructions. Check either YES or NO to each question. Do not answer N/A. If you answer YES to any of these questions, you must provide details on the Limited License Supplement. You must answer all questions or your application will be returned to you.

	YES	NO
14. Have you ever been enrolled in a postgraduate training program where you were required to repeat a year of training?		
If you answered "yes" to question 14, you must provide an explanation and a letter from the program director is required.		
15. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at any academic institution?		
16-A. Have you ever been terminated or granted a leave of absence, regardless of the reason, by a medical school or any postgraduate training program?		
16-B. Have you ever voluntarily left, transferred or withdrawn from a medical school or any postgraduate training program?		
16-C. Have you ever, for any reason, been placed on probation in medical school or any postgraduate training program?		
If you answered "yes" to 16-A, B or C, you must provide an explanation and request a letter of explanation from your medical school or postgraduate training program.		
17. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?		
18. Have you ever, for any reason, been denied a medical license, whether full, limited or temporary, or have you withdrawn an application for medical licensure?		
19. Have you ever voluntarily surrendered a license to practice medicine or any healing art?		

		YES	NO
20.	Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).		
21.	Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (See definition).		
22.	Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?		
23.	Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?		
24.	Have you ever voluntarily relinquished any medical staff membership, medical staff privileges or medical staff status?		
25.	Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?		
26.	Have you ever been charged with any criminal offense, other than a minor traffic offense?		
27.	Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		
28.	In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?		
29.	In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?		

CONFIDENTIAL MEDICAL INFORMATION

Before completing the following questions, refer to the instructions for definitions and additional information. If answering "yes" to any of the questions, you must provide details on the Limited License Supplement. For purposes of the following questions, "currently" does not mean on the day of, or even the weeks or months preceding the completion of this application. It means recently enough to have an impact on one's functioning as a licensee, or within the past two years.

	YES	NO
30. Since becoming a medical student, have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or function as a physician?		
31. Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?		
32. Within the past two years, have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?		
33. Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?		
34. Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?		
35. Within the past five years, have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?		

If your responses to Questions 15-35 change while your application is pending, you must notify the Board of the new information immediately. Please note that your license expires at the end of the academic year and must be renewed. A limited licensee may practice medicine only at the institution or its affiliates. With a limited license you are not allowed to "moonlight" under any circumstances.

CERTIFICATIONS:

- Pursuant to M.G.L. c. 62C, § 49A, I certify under the penalties of perjury that, to the best of my knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes that are required under law and that I have complied with all laws of the Commonwealth related to withholding and remitting child support. (*Note:* This applies even if you reside out of the state or out of the country.)
- Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, §51A.
- I will read the Board's regulations, 243 C.M.R. 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

- Under the penalties of perjury, I declare that I have examined this limited license application and all its accompanying instructions, forms and statements, and to the best of my knowledge, and belief, the information contained herein is true, correct and complete. As an applicant for a limited license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.

Applicant's Signature: _____ **Date:** 3/21/11

Revised: 8.12.08

SECTION B: TO BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL OF THE TEACHING PROGRAM AT WHICH THE APPLICANT HAS RECEIVED AN APPOINTMENT

This certifies that Ryan J. Montoya has been appointed
(Name of Applicant)

to the position of ☒ Intern ☐ Resident ☐ Fellow

in the specialty of FAMILY MEDICINE Fitchburg as a PGY 1

Department: Family Medicine, Fitchburg Subspeciality: _____

at UMass Memorial Medical Center
(Name of Healthcare Facility)

beginning 7 / 1 / 2011 to anticipated completion of training: 7 / 1 / 2014
(Month) (Day) (Year) (Month) (Day) (Year)

	YES	NO
1. Is the program accredited by the ACGME?	☒	☐
2. If **no**, is there an ACGME-approved training program in the applicant's specialty ?	☐	☐
3. Have you reviewed Sections A and C of the limited license application?	☒	☐

Designated Official's Signature: M P Leeds

Type or Print Name: Marilyn Leeds

Official Title: Administrative Director Graduate Medical Education

Date: 4 / 20 / 2011 Telephone Number: 508-890-3903

SECTION C: PAGES 4-6 MUST BE COMPLETED BY APPLICANT

Print F

Limited License

COMMONWEALTH OF MASSACHUSETTS--BOARD OF REGISTRATION IN MEDICINE
200 Harvard Mill Square, Suite 300, Wakefield, Massachusetts 01880

10/08/04/11

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, Ryan Joseph Montoya
(type/print your complete name)

request and authorize every person, institution, professional licensing board of any state in which I hold or may have held a license to practice my profession, hospital, clinic, government agency, (local, state, federal or foreign), law enforcement agency, or other third parties and organizations, and their representatives to release information, records, transcripts, and other documents, concerning my professional qualifications and competency, ethics, character, and other information pertaining to me to the Massachusetts Board of Registration in Medicine.

I further request and authorize that the requested information, documents and records be sent directly to:

Board of Registration in Medicine - 200 Harvard Mill Square, Suite 330
Wakefield, MA 01880 Telephone: (781) 876-8210 Fax: (781) 876-8383
www.massmedboard.org Attention: Licensing

Immunity and Release

I hereby extend absolute immunity to, and release, discharge, and hold harmless from any and all liability: 1) the Board of Registration in Medicine, its agents, representatives, directors and officers; 2) other agencies, institutions, hospitals and clinics providing information, their representatives, directors and officers; and 3) any third parties and organizations for any acts, communications, reports, records, transcripts, statements, documents, recommendations or disclosures involving me, made in good faith and without malice, requested or received by the Board of Registration in Medicine.

By my signature below, I acknowledge that information, documents and records required to be furnished by another organization, educational institution, hospital, individual or any person or groups of persons has been sent to me directly from the primary source in a sealed envelope and that none of the seals have been broken.

A photocopy or facsimile of this authorization shall be as valid as the original and shall be valid up to one year from the date signed.

Applicant's Signature

3/21/11
Date of Signature

Montoya, Ryan, J.
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

Applicant's Date of Birth (month/day/year)

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Limited Renewal Application

Physician Name: Ryan J Montoya, M.D. **License No.:** 248446

1. **Training Program**

   Current Training Program

   Facility: UMass Memorial Medical Center
   Program: Family Medicine

2. **Address & Contact Information**

   Mailing Address:
   UMass Memorial Medical Center
   55 Lake Avenue North
   Worcester
   Massachusetts - 01655
   United States of America

   Home Address:

3. **Email Address:**

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 248446

5. **Other states where you are now licensed to practice medicine**
   None Reported

SECTION B: To be completed by the Program Director.

Is\the above named physician in good standing in the training program?

Has the physician been subject to past or pending disciplinary action in this Program?

Name: James Ledwith MD **Date:** 2/6/2012
Designation: Program Director - Family Practic **Telephone:** (978) 878-8374

To be completed and signed by the designated official of the health care facility where the applicant has received an appointment.

This certifies that **Ryan J Montoya** has been appointed as **Resident**

Department of **Family Medicine**

Is the program accredited by the ACGME: Yes

Designated Official's Name: Marilyn P. Leeds **Date:** 2/7/2012
Designated Official's Title: Administrative Director Graduate **Telephone:** (508) 856-3250

6-A. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?

6-B. Have you, for any reason, been placed on probation in any postgraduate training program?

7. Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?

8. Have you, for any reason, been denied a medical license, whether full, limited or temporary or have you withdrawn an application for medical licensure?

9. Have you voluntarily surrendered a license to practice medicine or any healing art?

10. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).

11. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (see definition).

12. Have you been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?

13. Have you, for any reason, withdrawn an application for hospital privileges or appointment?

14. Have you voluntarily relinquished medical staff membership?

15. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?

16. Have you been charged with any criminal offense, other than a minor traffic offense?

17. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?

18. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved?

19. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?

20. Have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician?

21. Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?

22. Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?

23. Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?

24. Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?

25. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?

Compliance with Legal Responsibilities

1. I certify that I have complied with my obligations to report abuse of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.

2. I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c. 19A, sec. 15, and I understand the punishment for failure to comply.

3. I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.

4. I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A ½.

5. I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.

6. I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.

7. I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.

8. I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.

9. I will read the Board's regulations, 243 CMR 1.00 through 3.00.

10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

11. Under the penalties of perjury, I declare that I have examined this limited renewal application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete. As an applicant for renewal of a limited license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.

☒ **I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.**

☒ **Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.**

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Limited Renewal Application

Physician Name: Ryan J Montoya, M.D. **License No.:** 248446

1. **Training Program**

   Current Training Program

   Facility: UMass Memorial Medical Center
   Program: Family Medicine

2. **Address & Contact Information**

   Mailing Address:
   UMass Memorial Medical Center
   55 Lake Avenue North
   Worcester
   Massachusetts - 01655
   United States of America

   Home Address:

   United States of America

3. **Email Address:**

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 248446

5. **Other states where you are now licensed to practice medicine**
   None Reported

SECTION B: To be completed by the Program Director.

Is the above named physician in good standing in the training program? Yes

Has the physician been subject to past or pending disciplinary action in this Program?

Name: James Ledwith MD **Date:** 2/22/2013
Designation: Program Director - Family Practic **Telephone:** (978) 878-8374

To be completed and signed by the designated official of the health care facility where the applicant has received an appointment.

This certifies that **Ryan J Montoya** has been appointed as **Resident**

Department of **Family Medicine**

Is the program accredited by the ACGME: Yes

Designated Official's Name: Marilyn P. Leeds **Date:** 2/22/2013
Designated Official's Title: Administrative Director Graduate **Telephone:** (508) 856-3250

6-A. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?

6-B. Have you, for any reason, been placed on probation in any postgraduate training program?

7. Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?

8. Have you, for any reason, been denied a medical license, whether full, limited or temporary or have you withdrawn an application for medical licensure?

9. Have you voluntarily surrendered a license to practice medicine or any healing art?

10. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).

11. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (see definition).

12. Have you been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?

13. Have you, for any reason, withdrawn an application for hospital privileges or appointment?

14. Have you voluntarily relinquished medical staff membership?

15. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?

16. Have you been charged with any criminal offense, other than a minor traffic offense?

17. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?

18. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved?

19. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?

20. Have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician?

21. Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?

22. Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?

23. Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?

24. Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?

25. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?

Compliance with Legal Responsibilities

1. I certify that I have complied with my obligations to report abuse of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.

2. I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c. 19A, sec. 15, and I understand the punishment for failure to comply.

3. I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.

4. I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A ½.

5. I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.

6. I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.

7. I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.

8. I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.

9. I will read the Board's regulations, 243 CMR 1.00 through 3.00.

10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

11. Under the penalties of perjury, I declare that I have examined this limited renewal application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete. As an applicant for renewal of a limited license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.

[X] **I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.**

[X] **Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.**

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Ryan J Montoya, M.D. **License No.:** 266460

Current Status: Active **License Expiration Date:** 8/26/2016

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:

3) **Email Address:**

4) **Fax Number:**

5) **Specialties**
Family Medicine

6) **Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information**

ABMS/AOA	Board Name	Certification	Subspecialty
		None Reported	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) **Other states where you are now licensed to practice**
None Reported

9) **States where you were previously licensed**
None Reported

10) **Work Sites**
List of all work sites in Massachusetts, including health care facilities (where you are credentialed), private office, clinics, nursing homes, etc

WorkSite	Location
	None Reported

Physician Name: Ryan J Montoya, M.D. **License No.:** 266460

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 0 hrs/wk
b) outpatient care 0 hrs/wk

12) Medical Liability Insurance Information

I am not required to have malpractice insurance.

Not involved with direct or indirect patient care in Massachusetts.

13) Do you perform any surgery in your Massachusetts office? No

14) Claims Made
a) New: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period?
b) Pending: Are there any unresolved malpractice claims against you today, i.e., any claims that have not been resolved, settled or adjudicated during this time period?

15) Claims Closed
Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?

16) Other Civil Lawsuits
Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.
a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

17) Criminal Charges
a) Have you been charged with any criminal offense during this period?
b) Have any criminal offenses/charges against you been resolved during this time period?
c) Are there any criminal charges pending against you today?
d) Are any Application of Issuance of Process pending against you?

18) Other Issues
a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association?
b) Have you taken a leave of absence from any health care facility, group practice or employer for reasons related to your competence to practice medicine?
c) Have you been the subject of an investigation by any governmental authority, including the Massachusetts Board of Registration in Medicine or any other state medical board, health care facility, group practice, employer or professional association?
d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?

19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by or surrendered to any state or federal agency?

20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?

21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?

22) **Have you completed all of the CPD requirements for this renewal cycle? If you are renewing your license for the first time or participating in postgraduate training, please answer Yes.** Yes

23) **Do you have a medical condition that interferes in any way or limits your ability to practice medicine?**

24) **Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?**

Compliance with Legal Responsibilities

Online profile:
[X] I have reviewed my Physician Profile and confirm that the information is accurate.

1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.

2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.

3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.

4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.

5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.

6) I understand and agree to comply with my obligations to report a physician to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when I have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.

7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.

8) I understand and have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to M.G.L. c. 62C sec. 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury.

9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.

10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.

11) I understand and agree to comply with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to M.G.L c. 112 sec. 5 and 243 CMR 3.00 et seq. and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.

12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L c. 112 sec. 12AA.

13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.

14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.

15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

[X] **I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.**

[X] **Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.**

90-Day Form

Dear Doctor,

Renewal of your medical license will occur on your first birthday after your license is issued, unless your birthday falls within ninety (90) days of your license issue date. If your first birthday is within the 90-day time period that your license is issued, you will not be required to renew your license until your following birthday. Example: If your birthday falls on September 1, 2014, and your license is issued on July 1, 2014, your renewal date will be September 1, 2015. However, if your birthday falls on September 1, 2014, and your full license is issued on January 1, 2014, you will be required to renew your full license by your birthday on September 1, 2014. Renewals thereafter will be on a two-year birthday cycle. Please select one of the choices below and return this form with your Full License application.

Thank you.

Please select one of the boxes below:

☑ Do not hold my Full License Application; send it to the Board as soon as it is completed.

☐ Hold my Full License Application until it is within the 90-day time period.

My birthdate is _____ / _____ / _____
Month Day

Signature: _____ Today's Date: 2 / 26 / 16
Month Day Year

Please return this form with your Full License Application. If you do not submit this form with your Full License Application, your completed Full License Application will be forwarded to the Board for approval at the next Board meeting. Thank you.

266460

RECEIVED
MAR 2 2016
Board of Registration in Medicine

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.mass.gov/massmedboard

FULL LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of $600.00 made payable to the Commonwealth of Massachusetts. The application fee is non-refundable.

Type of License ☑ Initial Full License ☐ Administrative License ☐ Volunteer License

Check One: ☑ U.S./Canadian Graduate ☐ International Graduate

Legal Name (do not use nicknames or initials, unless they are part of your legal name)

MONTOYA RYAN JOSEPH
Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

☑ M.D. ☐ D.O. ☐ PhD ☐ Other degree _____ ☑ Male ☐ Female

Other Name(s) Used - List any other name(s) you have used which may appear on your identifying documents, such as medical education and examination records. If not applicable, check here. ☑

Entire Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

Social Security Number: _____ Date of Birth: _____
Month Day Year

NPI (National Provider Identifier) Number: 1003101973

Place of Birth: _____
City State/Province/Territory Country if not USA

*Mailing Address: _____ Telephone: _____
Number and Street

_____
City State/Province/Territory Zip (or postal) Code

Home Address: _____ Telephone: _____
Number and Street

_____
City State/Province/Territory Zip (or postal) Code

Business Address: N/A Telephone: N/A
Number and Street

N/A
City State/Province/Territory Zip (or postal) Code

E-mail Address: _____ Fax number: N/A

Are you applying for licensure through FCVS? ☐ **Yes** ☑ **No**

*** The Board will use your Mailing Address for all correspondence**

Date Received: 3/2/16

Check #: 287

Check Amount: $ 600.00

Initials: RF

Pre-medical School | **From** | **To**

Name: HARVARD COLLEGE Degree: BACHELOR OF ARTS Year: 2001 Year: 2005

Street: 86 BRATTLE STREET City: CAMBRIDGE State: MA

Name: _____ Degree: _____ Year: _____ Year: _____

Street: _____ City: _____ State: _____

Medical School

Name: UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL Degree: MEDICAL DOCTOR

Street: 55 LAKE AVENUE NORTH City: WORCESTER State: MA

Name: _____ Degree: _____

Street: _____ City: _____ State: _____

Medical School Graduation Date: 06 / 11
Month Year

Postgraduate Education:

List all postgraduate training in chronological order from medical school to the present. Include the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. You must account for all periods of training or postgraduate work from the time you graduated from medical school. Enter month and year only.

			From	**To**
Facility: UNIVERSITY OF MASSACHUSETTS FITCHBURG FAMILY MEDICINE RESIDENCY	PGY Year: 1,2,3		07 / 11	07 / 14
Specialty: FAMILY MEDICINE	City: FITCHBURG	State: MA		
Facility: _____	PGY Year: _____		___/___	___/___
Specialty: _____	City: _____	State: _____		
Facility: _____	PGY Year: _____		___/___	___/___
Specialty: _____	City: _____	State: _____		
Facility: _____	PGY Year: _____		___/___	___/___
Specialty: _____	City: _____	State: _____		
Facility: _____	PGY Year: _____		___/___	___/___
Specialty: _____	City: _____	State: _____		

Examination History

Please contact the appropriate examination entity and have the examination scores sent to you in a sealed envelope. If you are using FCVS, your examination scores will be sent to the Board with your credentials packet.

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, FLEX, COMVEX, COMLEX or a state examination.

Examination	Number of attempts	Passed (P) or Failed (F)	
USMLE Step I	2	☑ P	☐ F
USMLE Step II	1	☑ P	☐ F
USMLE Step III	1	☑ P	☐ F
NBME Part I		☐ P	☐ F
NBME Part II		☐ P	☐ F
NBME Part III		☐ P	☐ F
FLEX Component 1		☐ P	☐ F
FLEX Component 2		☐ P	☐ F
FLEX Pre-1985		☐ P	☐ F
NBOME Part I		☐ P	☐ F
NBOME Part II		☐ P	☐ F
NBOME Part III		☐ P	☐ F
COMLEX Level 1		☐ P	☐ F
COMLEX Level 2		☐ P	☐ F
COMLEX Level 3		☐ P	☐ F
COMVEX		☐ P	☐ F
LMCC – Single		☐ P	☐ F
LMCC – Part I		☐ P	☐ F
LMCC – Part II		☐ P	☐ F
State Board Exam	(State of examination and year)	☐ P	☐ F

Hospital Affiliations and Employment

List hospital appointments, in chronological order by month and year where you ever had medical staff privileges. Include the name and address of the facility, your position and dates of affiliation. Also include periods of unemployment or employment outside of medicine. Attach a separate sheet of paper if necessary.

		From	To
Facility: UMASS MEMORIAL HEALTHALLIANCE HOSPITAL	Position: PGY 1-3	07 / 11	07 / 14
Street: 60 HOSPITAL ROAD	City: LEOMINSTER	State: MA	
Facility: UNIVERSITY OF MASSACHUSETTS MEDICAL CENTER	Position: PGY 1-3	07 / 11	07 / 14
Street: 55 LAKE AVENUE NORTH	City: WORCESTER	State: MA	
Facility: UMASS MEMORIAL HOSPITAL	Position: PGY1-3	07 / 11	07 / 14
Street: 305 BELMONT STREET	City: WORCESTER	State: MA	

1. List other states (abbreviations) where you are currently or have ever had a full license: N/A
2. a) Are you certified by the American Board of Medical Specialties? ☐ Yes ☑ No
   b) Are you certified by the American Board of Osteopathic Medicine? ☐ Yes ☑ No
3. List Board Certification(s): N/A
4. List your practice specialt(ies): FAMILY MEDICINE (RESIDENCY TRAINED)
5. Have you completed the Opioid and Pain Management training? (See Instructions) ☑ Yes ☐ No
6. Have you completed training to recognize and report suspected child abuse or neglect? ☑ Yes ☐ No
   (Your license will not be processed until you complete the required training – see instructions.)
7. Reason for requesting a Massachusetts medical license: PLAN TO PRACTICE IN MASSACHUSETTS IN THE NEXT YEAR, LOOKING FOR POSITIONS.
8. Name of Facility: N/A
   Address: _____ City: _____
9. Anticipated starting date in Massachusetts: 09 / 01 / 2016
10. Curriculum vitae (CV) listing activities by month and year must be enclosed with your application. ✓

Under the penalties of perjury, I declare that I have examined this full application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete.

Signature of Applicant

2 / 26 / 2016
Month Day Year

COMMONWEALTH OF MASSACHUSETTS–BOARD OF REGISTRATION IN MEDICINE
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
www.mass.gov/massmedboard

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, RYAN JOSEPH MONTOYA
(type/print your complete name)

request and authorize every person, institution, professional licensing board of any state in which I hold or may have held a license to practice my profession, hospital, clinic, government agency (local, state, federal or foreign), law enforcement agency, or other third parties and organizations and their representatives to release information, records, transcripts and other documents concerning my professional qualifications and competency, ethics, character and other information pertaining to me to the Massachusetts Board of Registration in Medicine.

I further request and authorize that the requested information, documents, and records be sent directly to:

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01880

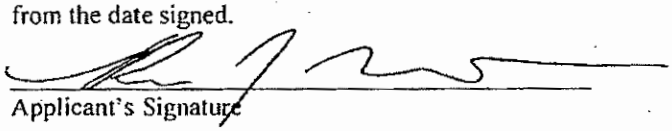
Attention: Licensing

Immunity and Release

I hereby extend absolute immunity to and release, discharge, and hold harmless from any and all liability: 1) the Board of Registration in Medicine, its agents, representatives, directors and officers; 2) other agencies, institutions, hospitals and clinics providing information, their representatives, directors and officers; and 3) any third parties and organizations for any acts, communications, reports, records, transcripts, statements, documents, recommendations or disclosures involving me, made in good faith and without malice, requested or received by the Board of Registration in Medicine.

By my signature below, I acknowledge that information, documents and records required to be furnished by another organization, educational institution, hospital, individual or any person or groups of persons has been sent to me directly from the primary source in a sealed envelope and that none of the seals have been broken. I understand that the Board of Registration in Medicine will not accept any such information, records or documents forwarded by me unless they are in sealed envelopes.

A photocopy or facsimile of this authorization shall be as valid as the original and shall be valid up to one year from the date signed.



Applicant's Signature

2/26/16
Date of Signature

MONTOYA, RYAN J
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

Applicant's Date of Birth (month/day/year)

ELECTRONIC HEALTH RECORDS (EHR) PROFICIENCY FORM

Pursuant to M.G.L. c. 112, § 2, an applicant for licensure must demonstrate proficiency in the use of electronic health records (EHR). This is a one-time requirement.

Complete Section 1 (Demonstrating Proficiency) OR Section 2 (Claiming an Exemption) and Sign in Section 3.

SECTION 1. DEMONSTRATING PROFICIENCY

1. I have demonstrated proficiency in the use of EHR in one of the following ways:

✓ Participation in a Meaningful Use program as an eligible professional;
___ Employment with, credentialed to provide patient care at, or in a contractual agreement with an eligible hospital or critical access hospital with a CMS Meaningful Use program;
___ Participation as either a Participant or an Authorized User in the Massachusetts Health Information Highway.
___ Completion of 3 hours of a Category 1 EHR-related CPD course that discusses, at a minimum, the core and menu objectives and the Clinical Quality Measures ("CQMs") for Meaningful Use.

SECTION 2. CLAIMING AN EXEMPTION (Exemptions must be claimed each licensing cycle, if applicable. If you are exempted from the EHR proficiency requirement, please select the appropriate exemption.) N/A

2. I am exempt from the EHR Proficiency requirement because I am an applicant

___ who will not be engaged in the practice of medicine as defined in 243 CMR 2.01(4);
___ for an Administrative License;
___ for a Volunteer License;
___ on active duty as a member of the National Guard or of a uniformed service called into service during a national emergency or crisis; or
___ for an Emergency Restricted License.

SECTION 3. SIGNATURE

I, the undersigned applicant, hereby certify that all information included in this EHR Proficiency Form constitutes a true statement made under penalties of perjury.

NAME: _____ DATE: 2/26/2016

RYAN JOSEPH MONTOYA

EDUCATION:

University of Massachusetts Fitchburg Family Medicine, Fitchburg and Leominster MA, July 2011 – July 2014
Family Medicine Residency Program

University of Massachusetts Medical School, Worcester MA, August 2005 – June 2011
Medical Doctor Degree

Harvard College, Cambridge MA, August 2001 – June 2005
Bachelor of Arts Degree, Biology With Honors Distinction

Boston Latin School, Boston MA, September 1995 – June 2001
High School Degree, With Honors

EXPERIENCE:

Medical School Application Liaison to U.S. State Department, Bosna i Hercegovina, August 2014 – Present
Advised, coordinated, and lectured across BiH about the application process and financial opportunities available to students living abroad, to attend U.S. medical schools and residency training programs.

General Lecturer, Family Medicine in the U.S., Bosna i Hercegovina, August 2014 – January 2016
Lectured about the state of the American Healthcare System to Family Medicine physicians living and practicing in BiH at multiple large speaking venues.

RiNG 2015 Researchers' Night, Banja Luka, Bosna i Hercegovina, August 2014 – September 2015
Europe-wide event initiated by the European Commission as part of the FP7 program to provide promote student scientific research in typically underserved areas. Worked as special coordinator and organizer, judge of young researcher projects, science debate moderator, and keynote speaker with a focus on HIV pathogenesis and emerging antiretroviral pharmacology.

RMA Group, Inc., Boston MA, September 1996 – Present
Group Fund Manager, Hedge Fund Manager, Research Analyst and Trading Advisor with over 15 years experience in providing task orienting market analyses to hedge fund investors. Act as biotechnology and pharmaceutical research analyst, providing detailed real-time market trend analysis to company traders.

Forsyth Institute Dental/Craniofacial Research, Boston MA, July 1998 – June 2005; August 2008 – June 2009
Researcher and Outreach Program Peer Leader in the Dr. Mark F. J. Maiden, Ph.D, Lab, Molecular Genetics Division/ Microbiology. Examined the molecular mechanisms of periodontal disease pathogenesis, developed novel approaches for mating systems, shuttle vectors, transposon mutagenesis methods, and the first successful transfer of plasmid and transposon vectors into B. forsythus. Extensive study of the molecular epidemiology of antibiotic resistance in B.forsythus through PCR and sequencing of human periodontal isolates carrying the tetQ gene for tetracycline resistance.

SKILLS:

Medicine
Term Prenatal and Perinatal Care Including Deliveries; Minor Outpatient Surgical Procedures; First Assist C-Section Deliveries, Cholecystectomies, Appendectomies; Proficiency in Plasti-Bell Circumcisions; Critical Care Procedures Including Central Venous Catheters, Thoracentesis, and Paracentesis; Joint Injections, Ultrasound-Guided Fluid Drainage; Trained in Suboxone Induction and Maintenance

Laboratory
Southern, Western, and Northern Blot Analysis; TA Cloning, Enzyme Digests, Vector Transformation, DNA Cycle Sequencing, Immunoblot DNA Detection, Midi/Maxi Prep Plasmid Purification Protocol; Full Plasmid Mapping; PCR Primer Design, Florescent In Situ Hybridization and Chromosome Painting; Microarray Gene Expression Analysis, Immunohistochemical Analysis, Magnetic Cell Sorting; Calcium Phosphate Transfection, Electroporation; Thin Layer and Flash Chromatography, S_N2 Acetylation, and Fischer Esterification

Languages
English, Latin, Filipino, Knowledge of Bosnian-Serbo-Croatian

Business
Bank Statement Reconciliation, Business Plan Evaluation, Financial Fundamentals Analysis

PUBLICATIONS:

Montoya, Ryan. "Comics and the Medical Encounter," January 2016. *Somatosphere. Accessed 22 Jan. 2016. <http://somatosphere.net/2016/01/comics-and-the-medical-encounter.html> Published essay describing my process in making a comic book story about practicing medicine*

Montoya, Ryan. "Sign Out," October 2015. *(Ann Intern Med. 2015;163(7):W141-W145. doi:10.7326/G15-0003) <http://annals.org/article.aspx?articleid=2450707> Published comic book short story, Annals of Internal Medicine Journal*

FMEC Philadelphia Poster Presentation, and STFM San Antonio Poster Presentation, November 2013 and May 2014. *Primary Presenter, "Optimizing Influenza Immunization in Diabetics in a Federally Qualified Health Center"*

AAFP Kansas City Family Medicine Conference, August 2012. *Keynote Speaker, "Evolving Model of Fee For Service in Light of Quality Care Measures"*

Graphic Medicine Website Founding Contributor, December 2013 – Present. *Comic book reviewer and essayist for online humanities in medicine website*

Journal of Dental Research: IADR Abstracts, September 2000. *(JDR Abstracts.Issue) Published as second author for continuing gene transfer and sequence analysis studies of the tetQ tetracycline resistance gene found in B. forsythus*

Journal of Dental Research: IADR Abstracts, June 1999. *(Volume 78, Issue 5) Published as a second author for gene transfer studies among B. forsythus and related periodontal isolates*

HONORS:

American Medical Association Family Medicine Delegate, Healthcare Reform, April 2013 – *Chosen as sole physician representative to advocate for Title VII and Title VIII funding for primary care and family medicine residencies*

Worcester District Medical Society Scholarship Recipient, 2006, 2008, 2010 – *Awarded to medical students for academic standing, leadership qualities, and commitment to medicine in the future*

Genzyme Biotechnology Scholarship Recipient, 2001, 2002, 2003, 2004 – *Four time recipient of the Genzyme Scholarship awarded to students of excellent academic record who have shown commitment towards a career in the life sciences*

Harvard College Scholarship, 2001, 2002 – *Two time recipient of award for broad academic excellence in undergraduate studies*

PRINT NAME: RYAN J. MONTOYA DATE: 2/26/16

FULL LICENSE APPLICATION SUPPLEMENT

IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide the additional information on pages 5-11.

QUESTIONS		YES	NO
1.	While enrolled in college, medical school, graduate school or postgraduate training were you ever the subject of any disciplinary action? (This includes action that was formal or informal, oral or written, voluntary or involuntary. A confidentiality agreement does not absolve you of your requirement to answer this question.)		
2-A.	Have you ever been terminated or granted a leave of absence by a medical school or any postgraduate training program or have you ever withdrawn from a medical school or any postgraduate training program or had to repeat a year of postgraduate training?		
2-B.	Have you ever been placed on probation or remediation by a medical school, graduate school or any postgraduate training program?		
3.	If you are a US or Canadian graduate, did you take more than four (4) years to complete medical school; or if you are an international medical graduate, did you take more than six (6) years to complete medical school?		
4.	Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of or found to have cheated or engaged in improper conduct during an examination?		
5.	Have you ever been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?		
6.	Have you ever surrendered a license to practice medicine or any professional license or has your license or certificate ever been revoked? (You do not need to report a lapsed license.)		
7.	Have you been denied American Board of Medical Specialties or American Board of Osteopathic Medicine certification or has your certification ever been suspended or revoked?		
8-A.	Are you aware of any pending investigation or inquiry into your professional conduct by any entity or are any disciplinary charges pending against you?		
8-B.	Since your completion of postgraduate training, has any disciplinary action ever been taken against you? (A confidentiality agreement does not absolve you of your requirement to answer this question.)		

PRINT NAME: RYAN J. MONTOYA DATE: 2/26/16

		YES	NO
9-A.	Have you ever relinquished any medical staff membership or association with a health care facility?		
9-B.	Has your medical staff membership, medical privileges, medical staff status or association with a health care facility ever been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee, administration or governing board?		
9-C.	Have you ever withdrawn an application for hospital privileges or appointment, or have you ever been denied medical staff membership, advancement in medical staff status or association with a health care facility, or has such denial been recommended by a medical staff committee, administration or governing body?		
10.	Have you ever been charged with any criminal offense? (You must report being arrested, arraigned, indicted or convicted, even if the charges against you were dropped, filed, dismissed, expunged or otherwise discharged. A charge of operating under the influence or its equivalent is reportable. A medical malpractice claim is a civil, not a criminal, matter and need not be reported for purposes of this question.)		
11.	Has your privilege to manufacture, distribute, administer, possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		
12.	Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?		
13.	Have you ever had an application for membership as a participating provider denied by any third-party payor, Medicare or Medicaid (any state) or have you ever been the subject of any termination, suspension or probation proceedings instituted by any third-party payor, Medicare or Medicaid (any state) or have you ever been restricted from receiving payments from any third-party payor, Medicare, Medicaid (any state)?		
14-A.	Has any medical malpractice claim ever been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved?		
14-B.	Has any lawsuit, other than a medical malpractice suit, ever been filed against you which is related to your practice of medicine or has such a suit been settled, adjudicated or otherwise resolved?		

PRINT NAME: RYAN J. MONTOYA DATE: 2/26/16

CONFIDENTIAL INFORMATION

If answering "yes" to any of the questions, provide details on the supplemental pages for questions 15 - 17. For purposes of the following questions, "currently" does not mean on the day of, or even the weeks or months preceding the completion of this application; it means recently enough to impact one's functioning as a physician.

		YES	NO
15.	Do you have a medical or physical condition that currently impairs your ability to practice medicine?		
16.	Have you engaged in the use of any substance(s) with the result that your ability to practice medicine is currently impaired?		
17.	Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?		

If you have a substance use disorder or mental or physical health diagnosis that impacts your ability to practice medicine, the Board encourages you to seek assistance voluntarily and to abide by any recommendations of your health care provider.

When the Board receives notice of a substance use disorder, its primary mission is to protect the public; however, the Board also seeks to ensure successful rehabilitation through the physician's participation in approved treatment programs and supervised structured aftercare. Similarly, when the Board receives notice of a mental health or physical health diagnosis that impacts a physician's ability to practice, the Board needs to ensure that the physician can practice medicine safely.

In regard to issues of physician impairment, whether the impairment is caused by a substance use disorder, or a mental or physical health diagnosis, the Board works cooperatively with the Massachusetts Medical Society's Physician Health Services (PHS) and encourages physicians to contact PHS to determine what services may be available to them in order to ensure their safe practice of medicine. Please call PHS at (781) 434-7404.

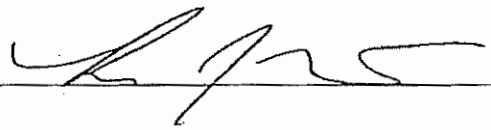
If your responses to Questions 1-17 change while your application is pending, you must immediately notify the Board of the new information.

PRINT NAME: RYAN J. MONTOYA DATE: 2/26/16

CERTIFICATIONS

- Pursuant to M.G.L. c. 112, § 2 and 243 CMR 2.07(15), I certify that I will not charge to or collect from a Medicare beneficiary more than the Medicare "reasonable charge" for services, in compliance with Chapter 475 of the Acts of 1985. (*Note:* Signing this certification does not imply that you will participate in the Medicare program).
- Pursuant to M.G.L. c. 62C, § 49A, I certify under the penalties of perjury that, to the best of my knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes that are required under law. (*Note:* This applies even if you reside out of the state or out of the country.)
- Pursuant to G.L.c. 62C, § 49A, to the best of my knowledge and belief, I am in compliance with G.L.c. 119A relating to withholding and remitting child support.
- Pursuant to M.G.L. c. 119, § 51A, I certify under the penalties of perjury that I will fulfill my obligation to report abuse or neglect of children.
- I will read the Board's regulations, 243 CMR 1.00 through 3.00.

I certify under the penalties of perjury that all information on this form, and all attached pages, is true, to the best of my knowledge.

Applicant's Signature:  Date: 2/26/16

Sealed Envelope
Initials: LS

Seal Verified
DATE: 3/3/16
INITIALS: LS

Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

INSTRUCTIONS TO THE APPLICANT: This form must be signed by a physician legally authorized to practice medicine in the United States. Someone who has known you for at least one year and is not a relative should execute this statement. The Board of Registration in Medicine prefers statements from physicians licensed to practice in Massachusetts. **The form must be notarized by a U.S. Notary Public.**

P
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CERTIFICATION OF MORAL AND PROFESSIONAL CHARACTER

This certifies that I have been personally acquainted with the physician named below:

Ryan J. Montoya MD
(name of applicant)

for 5 years. I believe that the above named physician is of good moral character and worthy of confidence and recommend him/her to the Massachusetts Board of Registration in Medicine.

Signature of applicant

Signature of Certifying Physician

I certify that the photograph above is a genuine likeness of the maker of the signature above.

226737 — License Number
MA — State

James J Ledwidge MD
Type or print name clearly

Signature of Notary

Address: HAEFP
345 Nichols Rd
City: Fitchburg State: MA Zip: 01420
Telephone: (978) 343-5292
Date: 02/29/2016

June 30, 2017
My commission expires

SHANICE RENEE WILLIAMS
Notary Public
Commonwealth of Virginia
7576565
My Commission Expires Jun 30, 2017

Instructions to the certifying physician: ***Please answer every question, date this form, and return it to the applicant in a sealed envelope with your signature across the seal.***

Board of Registration in Medicine, 200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.mass.gov/massmedboard

MEDICAL EDUCATION VERIFICATION

APPLICANT INSTRUCTIONS: Please complete the waiver for release of information and forward this form to your university/medical school(s) or university of graduation for verification. Please note: **Fourth year medical students must include the letter to the medical school registrar and Form B.**

Waiver for Release of Information

I authorize the medical school/university listed below to provide any and all information pertaining to my medical education at your institution.

Applicant's Signature: _____ Date of Birth: ____ ____ ____

Print or Type Name: MONTOYA (Last Name) RYAN (First Name) J (Middle Initial) U.S. Social Security No: _

Other Name(s): N/A
(Please type or print.)

Name of Medical School: UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL

Address: 55 LAKE AVENUE NORTH City: WORCESTER State or Province: MA

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete Form A and complete Form B if the above-named applicant has not been awarded a degree. Please include a copy of the official transcript (which indicates courses taken, dates and hours of attendance, scores, grades, or evaluations) and return to the applicant in a sealed envelope. Please sign or stamp across the seal on the envelope.

APPLICANT'S EDUCATIONAL HISTORY

If name of institution was different from the above-named institution when applicant attended, please enter name below:

_____

Premedical Education: Does your school have a premedical school education requirement? ☒ Yes ☐ No

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: Harvard College

Undergraduate School Address: Cambridge, MA 02138

Enrollment and Participation: Our records indicate that (print the applicant's name): Montoya (Last Name) Ryan (First Name) J (Middle Initial)

attended our medical school on the following dates (indicate the *month, day and year* separately **for each academic year** in the section below):

ATTENDANCE DATES:	FROM	TO	FROM	TO
	08 / 11 / 05	06 / 09 / 06	08 / 07 / 08	05 / 22 / 09
	08 / 10 / 06	06 / 01 / 07	07 / 06 / 09	06 / 25 / 10
	08 / 09 / 07	05 / 16 / 08	07 / 06 / 10	06 / 05 / 11

Graduation Date (month/year): 06 / 2011

The applicant attended 162 **total weeks *or*** _____ **total months (must be included) of not less than 32 weeks in each academic year of continuing on-campus education.**

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. All questions must be answered. If you answer "YES" to any of the questions below, please enclose an explanation.

	YES	NO
1. Was the medical school training more than four (4) years for U.S. graduates or six (6) years for international medical graduates?		
2. Did the applicant take any leaves of absence (i.e., for research, public service, participation in an M.D./Ph.D. program, or for any "personal reasons")?		
3. Was the applicant ever placed on probation?		
4. Was the applicant ever disciplined or under investigation?		
5. Were any negative reports ever filed by instructors regarding the applicant?		

Please provide a detailed explanation if you answered "YES" to any of the above questions.

AFFIX INSTITUTIONAL SEAL HERE

(If the institution does not have a seal, this form must be notarized.)

INTERNATIONAL MEDICAL SCHOOLS MUST ATTACH A COPY OF THE MEDICAL SCHOOL DIPLOMA AND A TRANSCRIPT OR PROVIDE AN EXPLANATION.

Signature: Michael F. Baker

Print Name: Michael F. Baker, M.A.

Title: Registrar

Date: 02/ 17 / 2016 Telephone: (508)856-2267

E-mail address: Registrar@umassmed.edu

This form must be stamped with the institutional seal or notarized. Please return to the applicant with the medical school transcripts in a sealed envelope with the signature of the Dean or the seal of the medical school affixed on the back of the envelope. Thank you.

Seal Verified
DATE: 3/3/16
INITIALS: LS

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383

POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below, as requested by the Massachusetts Board of Registration in Medicine.

Applicant's Signature: _____ Date: 2/12/16

Print or Type Name: RYAN J. MONTOYA

Name of Institution: UNIVERSITY OF MASSACHUSETTS FITCHBURG FAMILY MEDICINE RESIDENCY

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a sealed envelope, signed across the seal. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: UMass Fitchburg Family Medicine Residency

If name of Institution was different when applicant attended, please enter name: _____

Enrollment and Participation: Our records indicate that RYAN J. MONTOYA (Print applicant's name) participated in the following program:

(List each year separately with from and to dates)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
RESIDENCY	1	FAMILY MEDICINE	7-1-11	6-30-12	Yes	ACGME
RESIDENCY	2	FAMILY MEDICINE	7-1-12	6-30-13	Yes	ACGME
RESIDENCY	3	FAMILY MEDICINE	7-1-13	6-30-14	YES	ACGME

(Continued on page 2)

APPLICANT'S NAME: Ryan J. Montoya

POSTGRADUATE VERIFICATION FORM PAGE - 2

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please circle the appropriate response. **If you answer yes to any of these questions, please enclose an explanation.**

QUESTIONS	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training?		—
2. Was the applicant ever placed on probation?		—
3. Was the applicant ever disciplined or under investigation?		—
4. Were any negative reports ever filed by instructors regarding the applicant?		—
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		—

Seal Verified
DATE: 3/3/16
INITIALS: LS

6. During the applicant's participation, our postgraduate medical training ☒ was accredited by: ☒ ACGME ☐ Other: _____

COMMENTS: Excellent performance. Highly Recommended.

AFFIX INSTITUTIONAL SEAL HERE

(If the institution does not have a seal, this form must be notarized by a notary public.)

CATHERINE A. FAIOLA
Notary Public
COMMONWEALTH OF MASSACHUSETTS
My Commission Expires
January 13, 2023

Catherine A. Faiola 2/23/2016

Certification: I hereby certify that the above information is correct, to the best of my knowledge.

Program Director's Signature: _____

Print Name: James J. Ledwith Jr MD

Academic Title: Residency Director

Telephone: (978) 343-5270 Today's Date: 02/23/2016

E-mail address: james.ledwith@umassmemorial.org

PLEASE RETURN THIS COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPED WITH YOUR SIGNATURE ACROSS THE SEAL OF THE ENVELOPE.

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383
www.mass.gov/massmedboard

EVALUATION FORM

I hereby authorize the representatives or staff of the facility listed below to provide the *Board of Registration in Medicine* with any and all information requested in this evaluation form, whether such information is favorable or unfavorable, and I hereby release from any and all liability the named facility and/or any person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Signature of applicant: _____ Date: 2 / 12 / 16

Please PRINT your name: RYAN J. MONTOYA

Name of facility: UNIVERSITY OF MASSACHUSETTS FITCHBURG FAMILY MEDICINE RESIDENCY State: MA

INSTRUCTIONS TO THE CHIEF OF SERVICE, PROGRAM DIRECTOR OR SUPERVISOR, WHO MUST BE A PHYSICIAN: Please complete items #1-7 below and return to the applicant with your name affixed across the envelope seal.

1. How long have you worked with the applicant? From: 07 / 01 / 2011 To: 06 / 30 / 2014

   A. In what capacity? ☒ supervisory ☐ other: _____

   B. Date(s) of applicant's affiliation at facility: From: 07 / 01 / 2011 To: 06 / 30 / 2014

   C. Applicant's Status: ☐ Intern ☒ Resident ☐ Fellow ☐ Staff Member ☐ Other _____

2. Has the applicant's privileges to admit or treat patients ever been modified, suspended, reduced or revoked? ☒ No ☐ Yes (if "yes" please explain below)

   _____

   _____

3. Please rate the following (if "BELOW AVERAGE or "POOR", explain in detail on the back of this evaluation and/or attach a separate sheet).

	Superior	Above Average	Average	Below Average	Poor
Clinical knowledge			X		
Clinical competency		X			
Professional judgment		X			
Character and ethics	X				
Technical skills		X			
Relationships with staff	X				
Relationship with patients	X				
Cooperativeness/ability to work with others	X				

(Continued on page 2)

4. Has this applicant ever been the subject of disciplinary action or had staff privileges, employment or appointment at this hospital or facility voluntarily or involuntarily denied, suspended, revoked or has (s)he resigned from the medical staff in lieu of disciplinary action? If "yes" please explain below. ☒ NO ☐ YES

5. PLEASE COMMENT ON THE PHYSICIAN'S STRENGTHS OR WEAKNESSES AND/OR ANY OTHER INFORMATION THAT YOU MAY HAVE TO ASSIST IN THIS EVALUATION.

Excellent interpersonal skills and professional character.
Excellent judgement and awareness of personal limitations

6. The above comments are based on the following:

- ☒ Close personal observation
- ☐ General impression
- ☒ A composite of previous evaluations by other physicians
- ☐ Other _____

7. RECOMMENDATIONS:

- ☒ Recommend for licensure in Massachusetts.
- ☐ Recommend for licensure in Massachusetts, with the following reservations:

_____

- ☐ Do not recommend for the following reason(s):

_____

Signature: _____ (check one) ☒ M.D. or ☐ D.O.

Print Your Name: James J. Ladwith Jr MD Date: 02/23/2016

Academic title or position: Residency Director Phone number: 978-343-5270

Specialty/Service ~~or~~ Department: Family Medicine

E-mail address: james.ladwith@umassmemorial.org

PLEASE RETURN THE COMPLETED EVALUATION TO THE APPLICANT IN A SEALED ENVELOPE WITH YOUR SIGNATURE AFFIXED ACROSS THE ENVELOPE SEAL.

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Ryan J Montoya, M.D. **License No.:** 266460

Current Status: Active **License Expiration Date:** 8/26/2018

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:

3) **Email Address:**

4) **Fax Number:**

5) **Specialties**
Family Medicine

6) **Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information**

ABMS/AOA	Board Name	Certification	Subspecialty
		None Reported	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) **Other states where you are now licensed to practice**
None Reported

9) **States where you were previously licensed**
None Reported

10) **Work Sites**
List of all work sites in Massachusetts, including health care facilities (where you are credentialed), private office, clinics, nursing homes, etc

WorkSite	Location
	None Reported

Physician Name: Ryan J Montoya, M.D. **License No.:** 266460

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 0 hrs/wk
b) outpatient care 0 hrs/wk

12) Medical Liability Insurance Information

I am not required to have malpractice insurance.

Not involved with direct or indirect patient care in Massachusetts.

13) Do you perform any surgery in your Massachusetts office? No

14) Claims Made
a) New: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period?
b) Pending: Are there any unresolved malpractice claims against you today, i.e., any claims that have not been resolved, settled or adjudicated during this time period?

15) Claims Closed
Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?

16) Other Civil Lawsuits
Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.
a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

17) Criminal Charges
a) Have you been charged with any criminal offense during this period?
b) Have any criminal offenses/charges against you been resolved during this time period?
c) Are there any criminal charges pending against you today?
d) Are any Application of Issuance of Process pending against you?

18) Other Issues
a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association?
b) Have you taken a leave of absence from any health care facility, group practice or employer for reasons related to your competence to practice medicine?
c) Have you been the subject of an investigation by any governmental authority, including the Massachusetts Board of Registration in Medicine or any other state medical board, health care facility, group practice, employer or professional association?
d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?

19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by or surrendered to any state or federal agency?

20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?

21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?

22) **Have you completed all of the CPD requirements for this renewal cycle? If you are renewing your license for the first time or participating in postgraduate training, please answer Yes.** Yes

23) **Do you have a medical condition that interferes in any way or limits your ability to practice medicine?**

24) **Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?**

25) MassHealth Enrollment Status
I have submitted a completed application to MassHealth to be either a fully participating provider or a nonbilling provider.

Compliance with Legal Responsibilities

Online profile:
[X] I have reviewed my Physician Profile and confirm that the information is accurate.

1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.

2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.

3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.

4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.

5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.

6) I understand and agree to comply with my obligations to report a physician to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when I have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.

7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.

8) I understand and have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to M.G.L. c. 62C sec. 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury.

9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.

10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.

11) I understand and agree to comply with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to M.G.L. c. 112 sec. 5 and 243 CMR 3.00 et seq. and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.

12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L. c. 112 sec. 12AA.

13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.

14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.

15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

16) By signing this form, I am providing my consent for the Massachusetts Board of Registration in Medicine and, where relevant, their supervising state agencies and the Massachusetts Executive Office of Health and Human Services, and where relevant, its provider enrollment vendor, to obtain, read, copy, and share with each other information regarding my MassHealth application and enrollment status and Massachusetts licensure status.

Physician Name: Ryan J Montoya, M.D. **License No.:** 266460

[X] I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.

[X] Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.

RYAN J. MONTOYA
D.O. 266460

RECEIVED
AUG 31 2018
Board of Registration in Medicine

Commonwealth of Massachusetts
Board of Registration in Medicine

200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
Telephone (781) 876-8230
www.mass.gov/massmedboard

WAIVER FOR RELEASE OF INFORMATION

Completion of this waiver will authorize the release of information from the Board of Registration files to the entity listed below. This waiver form must be properly executed and no other waiver form is acceptable.

Information released pursuant to this waiver is based entirely on review of open and closed complaint files and does not include information in the license application, renewal application, or any documentation that the Board of Registration is required to obtain by statute, e.g. court documents, insurance verifications, and information from health care entities.

"I hereby authorize and direct the Massachusetts Board of Registration in Medicine to release any and all information it may have in its possession or control, including but not limited to the substance of any complaints or communication it may have received and the action or actions it may have taken in response, to the entity named **below:"**

(Please type or print clearly.)

BOARD OF MEDICINE - MD/DO NEW APPLICATION

SEND LICENSE VERIFICATION TO: HRLA 1

ADDRESS: P.O. Box 37601

CITY: WASHINGTON STATE: D.C. ZIP: 20013

PHYSICIAN'S NAME: DR. RYAN JOSEPH MONTOYA

BUSINESS ADDRESS: 26 HIGH ROCK WAY

CITY: ALLSTON STATE: MA ZIP: 02134

MASSACHUSETTS LICENSE NUMBER: 266460

SIGNATURE OF PHYSICIAN: [signature] 8/31/18

Signed under the penalties of perjury

DATE: 8/24/18

Check # 294

Amount $ 100.00

Initials: KF

This release shall remain valid for one (1) year from the date of execution.

11/04/11 28 08/04/11

DOCUMENTS RECEIVED FROM DESIGNATED OFFICIAL

This is to confirm that

Physician's Name: Ryan (First Name) _____ (Middle Initial) Montoya (Last Name)

is applying for a limited license in Massachusetts. I received and opened the documents listed below that were sent to me by the physician in sealed envelopes or directly from the primary source:

- [x] Medical school verification form
- [ ] Medical school transcripts
- [ ] Letter from program director
- [ ] Evaluations
- [ ] Leave of absence
- [ ] Other documents (describe): _____

I hereby certify under the penalties of perjury that I have not altered the attached documents and they are forwarded to the Board of Registration in Medicine, with the original envelopes attached, as received by me.

Designated Official: Dawn Hemp Date: / /

Title: Administrator Grad Med Ed

Name of Institution: Umass Medical School

NOTE: **Malpractice complaints, dismissals and other legal documents must be sent directly to the Board of Registration in Medicine from the primary source.**

Affix institutional seal or if the institution does not have a seal, this form must be notarized.

Zip/Limitedrelease/2